Summary of Policy Changes from HHPPS Proposed Rule Published on October 28, 1999 Compared to Final Rule

PROPOSED RULE	FINAL RULE
Statutory Effective Date for All Medicare Participating HHAs: 10/1/00	Unchanged
For Eligible Beneficiaries Under a Home Health Plan of Care: • 60 Day Episode Payment-National Rate without blended transitional payments • 60 Day Episode Rate Includes Home Health Services Previously Paid on a Reasonable Cost Basis: 6 Disciplines of Home Health Care (Skilled Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, Speech Language Pathology Medical Social Services) and Medical Supplies (Routine & Non-Routine Medical Supplies) Additional Payments Will be Made for Covered Injectable Osteoporosis Drugs and DME.	Unchanged
Non-Standardized PPS Amount Per 60-Day Episode for FY 2001: Home Health Aide = $732.80 Medical Social Services = 55.45 Occupational Therapy = 49.82 Physical Therapy = 283.75	Non-Standardized PPS Amount Per 60-Day Episode for FY 2001: Home Health Aide = $559.45 Medical Social Services = 49.15 Occupational Therapy = 55.52 Physical Therapy = 317.35

PROPOSED RULE	FINAL RULE
Skilled Nursing = 1,389.97 Speech Pathology = 20.32 Non-Routine Med. Supply = 52.78 (included on cost report Non-Routine Med. Supply = 10.35 (billed Part B carrier) Therapies = None OASIS = None (one-time adjustment) OASIS = 4.32 (ongoing costs) **Total Non-Standardized PPS Amount Per 60-Day Episode for FY 2001 = $2,599.56**	Skilled Nursing = 1,337.04 Speech Pathology = 20.39 Non-Routine Med. Supply = 43.54 (included on cost report Non-Routine Med. Supply = 6.08 (billed Part B carrier) Therapies = 17.67 OASIS = 5.50 (one-time adjustment) OASIS = 4.32 (ongoing costs) **Total Non-Standardized PPS Amount Per 60-Day Episode for FY 2001 = $2,416.01**
Standardized PPS Amount Per 60-Day Episode for FY 2001 determined as follows: Non-Standardized PPS Amount for FY 2001 = $2,599.56 Divided by Wage Index and Case Mix Adjustment Factor 0.95502 = $2,721.99 Multiplied by Budget Neutrality Factor .78578 = 2,138.89 Divided by Outlier Factor 1.05 = **Standardized PPS Amount Per 60-Day Episode for FY 2001 of $2,037.04**	Standardized PPS Amount Per 60-Day Episode for FY 2001 determined as follows: Non-Standardized PPS Amount for FY 2001 = $2,416.01 Divided by Wage Index and Case Mix Adjustment Factor 0.96184 = $2,511.86 Multiplied by Budget Neutrality Factor .88423 = 2,221.06 Divided by Outlier Factor 1.05 = **Standardized PPS Amount Per 60-Day Episode for FY 2001 of $2,115.30**

PROPOSED RULE	FINAL RULE
Included in National 60 Day Episode Rate: Amount included for Average Cost per Episode for Non-Routine Medical Supplies Included under Home Health Benefit Reported on Cost Report in the 60 Day National Episode Rate = $52.78	Included in National 60 Day Episode Rate: Amount included for Average Cost per Episode for Non-Routine Medical Supplies Included under Home Health Benefit Reported on Cost Report in the 60 Day National Episode Rate = $43.54
Included in National 60 Day Episode Rate: Average Cost per Episode for Non-Routine Medical Supplies Possibly Unbundled and Billed to Part B while under a home health episode in CY 1997 (199 HCPCS Codes) = $10.35	Included in National 60 Day Episode Rate: Average Cost per Episode for Non-Routine Medical Supplies Possibly Unbundled and Billed to Part B while under a home health episode in CY 1998 (178 HCPCS codes) based on analysis in response to public comments) = $6.08
Not Included in National 60 Day Episode Rate	Included in National 60 Day Episode Rate: In response to comments, provided similar analysis on Part B therapies that could have been unbundled to Part B while under a home health plan of episode in CY 1998= $17.67
Included in National 60 Day Episode Rate: Average Payment Per Episode for Ongoing Oasis Adjustment Costs = $4.32	Included in National 60 Day Episode Rate: Average Payment Per Episode for Ongoing Oasis Adjustment Costs = $4.32
Not Included in National 60 Day Episode Rate	Included in National 60 Day Episode Rate: In response to comments, provided a one time first year implementation cost for OASIS form changes = $5.50 per

PROPOSED RULE	FINAL RULE
	episode
National 60 Day Episode Standardization Factor for Wage Index & Case Mix (Abt Data Only) .95502	National 60 Day Episode Standardization Factor for Wage Index & Case Mix (Abt Data & National OASIS Data) .96184
Budget Neutrality Factor-PPS Budget Neutral to IPS in FY 2001 With Limits Reduced by 15% • .**78578** ($17,599 million projected IPS in FY 2001 with limits reduced by 15%/$22,346 million projected PPS in FY 2001) • Estimated Episodes =8.985 million • Projected Outlays for PPS FY 2001 = $22,346 million • Projected Outlays for IPS in FY 2001 w/limits reduced by 15% = $17,559 million ($17,466 million + $93 million for non-routine medical supplies that could have been unbundled to Part B prior to PPS)	Budget Neutrality Factor-PPS Budget Neutral to IPS in FY 2001(BBRA of 1999 postponed 15% reduction in the budget neutrality target for one year) • **.88423** ($11,382 million projected IPS in FY2001- $57.25 million projected LUPA episodes in FY 2001 before budget neutrality/$12,807 million projected PPS in FY 2001) • Estimated Episodes = 5.580 million • Projected Outlays for PPS FY 2001 = $12,807 million • Projected Outlays for IPS in FY 2001=$11,382 million ($11,273 million FY2001 President's Budget Assumptions + $109 million for Part B Therapies that could have been unbundled to Part B prior to PPS)
Outlier Adjustment Factor for 60 day episode rate calculation = 1.05	Unchanged
CY 1997 Average Utilization Data from Episode File - Episodes w/5 or more visits Average number of visits for episodes w/5 or more visits from **CY 1997** Episode File. Home Health Aide = 17.59	CY 1998 Average Utilization Data from Episode File - Episodes w/ 5 or more visits. Average number of visits for episodes w/5 or more visits from **CY 1998** Episode File. Home Health Aide=13.4

PROPOSED RULE	FINAL RULE
Medical Social Services = .36 Occupational Therapy = .48 Physical Therapy = 2.74 Skilled Nursing = 14.69 Speech Pathology = .18 Total = 36.04	Medical Social Services = .32 Occupational Therapy = .53 Physical Therapy = 3.05 Skilled Nursing = 14.08 Speech Pathology = .18 Total = 31.56
Representative Sample Audited Cost Report Data - CR Years Ending in FY 1997 • Average Cost Per Visit from the PPS Audit Sample Home Health Aide=$41.66 Medical Social Services = $154.03 Occupational Therapy = $103.79 Physical Therapy = $103.56 Skilled Nursing = $94.62 Speech Pathology = $112.91	Representative Sample Audited Cost Report Data - CR Years Ending in FY 1997- **Updated** Average Cost Per Visit from the PPS Audit Sample-**Updated** Home Health Aide=$41.75 Medical Social Services = $153.59 Occupational Therapy = $104.76 Physical Therapy = $104.05 Skilled Nursing = $94.96 Speech Pathology = $113.26
Continuous Certifications for Eligible Beneficiaries	Unchanged
Split Percentage Payment Approach Initial **50%** of the 60-day case mix and wage-adjusted episode paid at the onset of the episode and the residual 50% paid at the end.	Split Percentage Payment Approach For first episodes, initial **60%** of the 60-day case mix and wage-adjusted episode paid at the onset of the episode and the residual 40% paid at the end. Subsequent episodes for eligible beneficiaries who require continuous home care are paid at the 50/50 percentage split.
Rules Governing Split Percentage Payments • New Notice of Admission Identifies the	Rules Governing Split Percentage Payments • No need for proposed notice of

PROPOSED RULE	FINAL RULE
HHA as primary for the 60-Day Episode. • Initial Claim submitted for initial percentage payment based on signed plan of care.	admission due to the new request for anticipated payment (RAP) approach based on physician verbal orders and documentation. • RAPs are not considered initial claims • RAPs can be submitted before the physician signs the plan of care. If a physician signed plan of care is not available at the beginning of the episode, the HHA may submit a RAP for the initial percentage payment based on physician verbal orders. • The RAP must be based on a physician's verbal order that is: Recorded in the plan of care Includes a description of the patient's condition and the services to be provided by the home health agency Includes an attestation (relating to the physician's orders and the date received) signed and dated by the registered nurse or qualified therapist (as defined in 42 CFR 484.4) responsible for furnishing or supervising the ordered service in the plan of care, and • The plan of care is copied and is immediately submitted to the physician or a referral prescribing detailed orders for the services to be rendered that is signed and dated by the physician. • RAPs are not subject to the payment floor • HCFA has the authority to reduce or disapprove requests for anticipated payments in situations where protecting Medicare program's integrity warrants this action

PROPOSED RULE	FINAL RULE
Final Claim submitted for residual percentage payment based on signed plan of care.	integrity warrants this action. • Since the RAP can be based on verbal orders and is not considered a Medicare claim the RAP may be canceled and recovered unless the claim is submitted within the greater of 60 days from the end of the episode or 60 days from the issuance of the RAP payment. • A RAP is considered a claim for purposes of Federal, civil, criminal, and administrative law enforcement, including but not limited to the Civil Monetary Penalties law, Civil False Claims Act and the Criminal False Claims Act). • The plan of care must be signed and dated by a physician as described who meets the certification and re-certification requirements of section 424.22 before the claim for each episode for services is submitted for the final percentage payment (40% for new patients and 50% for subsequent episodes). Any changes in the plan of care must be signed and dated by a physician. • No Change-Final Claim submitted for residual percentage payment based on signed plan of care.
Law Eliminates Periodic Interim Payments with implementation of PPS	Unchanged
Low Utilization Payment Adjustment (LUPA)	Low Utilization Payment Adjustment (LUPA)

PROPOSED RULE	FINAL RULE
• Four or Fewer Visit Threshold • Episodes with four or fewer visits are paid the national average per visit amounts for FY 2001. • Per visit amounts will be further divided into a wage adjusted labor portion and a non-labor portion: Home Health Aide = $34.44 Medical Social Services = $123.31 Occupational Therapy Services = $83.57 Physical Therapy Services = $83.39 Skilled Nursing Services = $76.32 Speech Pathology Services = $90.79 • LUPA Rate Components Reflected in Proposed Amounts Listed Above: • Average per visit cost for non-routine medical supplies reported on the cost report = $1.41 • Average cost per visit for non-routine medical supplies that could have been unbundled to Part B prior to PPS = $0.35 • Average cost per visit for ongoing OASIS reporting =$.12 • Standardization factor for wage index = .94622 • Budget Neutrality Factor = .78578 • Outlier Adjustment = 1.05	• Retained Four or Fewer Visit Threshold • Episodes with four or fewer visits are paid the recomputed national average per visit amounts FY 2001 (Included additional OASIS and therapy adjustments). • Per visit amounts will be further divided into a wage adjusted labor portion and a non-labor portion: Home Health Aide = $43.37 Medical Social Services = $153.55 Occupational Therapy Services = $105.44 Physical Therapy Services = $104.74 Skilled Nursing Services = $95.79 Speech Pathology Services = $113.81 • LUPA Rate Components Reflected in Final Amounts Listed Above: • Average per visit cost for non-routine medical supplies reported on the cost report = $1.71 • Average cost per visit for non-routine medical supplies that could have been unbundled to Part B prior to PPS = $0.23 • Average cost per visit for ongoing OASIS reporting =$.12 • Average Cost per visit for one-time OASIS scheduling Implementation Change = $.21 • Standardization factor for wage index = .96674 Budget Neutrality Factor = Not Applicable Outlier Adjustment = 1.05

PROPOSED RULE	FINAL RULE
Significant Change In Condition (SCIC) Payment Adjustment • If a patient experiences a significant change in condition that was not envisioned in the original plan of care, the HHA may adjust the payment level to reflect the resources needed to treat the significant change in condition. The SCIC adjustment is a proportional payment adjustment reflecting the time both before and after the patient experienced the significant change in condition during the episode. The SCIC adjustment does not restart the 60-day episode clock. The SCIC adjustment occurs within an episode. • In order to receive a new case mix assignment for the purposes of a SCIC adjustment during the 60 day episode, the HHA must complete an OASIS assessment and obtain necessary physician change orders reflecting the significant change in treatment approach in the patient's plan of care. • The first part of the SCIC adjustment is calculated by taking the span of days (first billable visit date through the last billable visit date) before the patient experienced the significant change as a proportion of 60 multiplied by the original case mix and wage adjusted 60 day episode. • The second part of the SCIC adjustment is calculated by taking the span of days (first billable visit date through the last billable visit date) after	Significant Change In Condition (SCIC) Payment Adjustment Unchanged

PROPOSED RULE	FINAL RULE
the patient experienced the significant change as a proportion of 60 multiplied by the new case mix and wage adjusted 60 day episode for the balance of the episode. • The therapy threshold for case mix purposes applies to the total 60-day episode. In the case of a SCIC adjusted episode, the therapy threshold applies cumulatively to the total episode.	
Partial Episode Payment Adjustment (PEP Adjustment) • In case of beneficiary elected transfer or discharge and return to the same HHA during a 60-day episode, the original episode is closed out with a proportional payment. A new 60 day episode clock for payment, OASIS assessment & plan of care certification begins as a result of the beneficiary elected transfer or discharge and return to the same HHA during a 60 day episode. • Proportional payment is calculated using span of days (first billable visit through last billable visit) as a proportion of 60 multiplied by the original case mix and wage adjusted 60-day episode payment. • PEP Adjustment does not apply under circumstances of HHAs under common ownership as defined in PRM 1004. Those situations are under arrangement.	Partial Episode Payment Adjustment (PEP Adjustment) • In case of beneficiary elected transfer or discharge and return to the same HHA during a 60-day episode, the original episode is closed out with a proportional payment. A new 60 day episode clock for payment, OASIS assessment & plan of care certification begins as a result of the beneficiary elected transfer or discharge and return to the same HHA during a 60 day episode. • Retained billable visit dates: Proportional payment is calculated using span of days (first billable visit through last billable visit) as a proportion of 60 multiplied by the original case mix and wage adjusted 60 day episode payment • PEP adjustment does not apply in circumstances of HHAs under common ownership as defined in 42 CFR 424 for the balance of the 60-day episode, unless the beneficiary moves out of the MSA or non-MSA during the

PROPOSED RULE	FINAL RULE
	episode. Situations that meet the definition of common ownership are considered to be under arrangement.
• The therapy threshold for case mix purposes applies separately to the proportional adjustment and the resulting new episode.	• The therapy threshold for case mix purposes applies separately to the proportional adjustment and the resulting new episode.
Cost Outlier Payments-holding estimated outlays at 5% • Fixed Dollar Loss of 107% of the 60 day national standardized episode amount • Loss Sharing Ratio = 60% • Imputed Cost Amounts for Episode = Per Visit Amounts from NPRM Table 6 Wage Adjusted for Beneficiary Site of Service • Wage Adjusted (outlier threshold & imputed amounts)	Cost Outlier Payments-holding estimated outlays at 5% • Fixed Dollar Loss of 113% of the 60 day national standardized episode amount • Loss Sharing Ratio=80% • Imputed Cost Amounts for Episode = Per Visit Amounts from Final Regulation Table 6 Wage Adjusted for Beneficiary Site of Service • Wage Adjusted (outlier threshold & imputed amounts)
Case Mix • 80 Groups • 19 OASIS Items & Therapy Variable • Clinical, Functional, Intensity of Service Domains	Case Mix • 80 Groups • 23 OASIS Items (Including new Therapy Variable) • Changes Designed to give more weight to serious conditions, particularly wounds and wound related conditions. • Clinical Domain MO240-Added Secondary Diagnosis due to manifestation of underlying medical condition. Only codes from original list in NPRM that must be coded secondary. MO440-Added Wound/Lesion

PROPOSED RULE	FINAL RULE
	distinction for Burns & Trauma Diagnoses in MO230. MO450 –Added Multiple Pressure Ulcers-split stages of ulcers-added points for 2 or more stage 3 or 4 pressure ulcers • Functional Domain-Retained • Intensity of Service Domain MO175-Distinction between previous stay in SNF versus Nursing Home. MO825-New Therapy Threshold Variable.
Wage Index-Adjusts Labor Portion of Rates • Based on Site of Service of Beneficiary • Applies to 60-day Episode Rates, SCIC Adjustments, PEP Adjustments, LUPA Rates and Outlier calculations • Calculations use the latest pre-floor and pre-reclassified hospital wage index	Unchanged-latest version of pre-floor & pre-reclassified hospital wage index
Proposed Requirement Physician must certify the HHRG as part of the plan of care certification requirements.	Eliminated Proposed Requirement Physician must certify the HHRG as part of the plan of care certification requirements
Consolidated Billing Requirements Govern all Covered Home Health Services listed in 1861(m) of the Social Security Act. • 6 Disciplines of Home Health • Routine & Non-Routine Medical Supplies	Consolidated Billing Requirements Govern all Covered Home Health Services listed in 1861(m) (except durable medical equipment) of the Social Security Act. • 6 Disciplines of Home Health • Routine & Non-Routine Medical Supplies

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<tr><th>PROPOSED RULE</th><th>FINAL RULE</th></tr>
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• Durable Medical Equipment
• Covered Injectable Osteoporosis Drug

HHA must bill Medicare for the services governed by the Consolidated Billing Requirements. As long as the HHA bills Medicare directly for payment for these items or services, HHA may provide these services either directly or under arrangement.
</td><td>
• Covered Injectable Osteoporosis Drug

HHA must bill Medicare for the services governed by the Consolidated Billing Requirements. As long as the HHA bills Medicare directly for payment for these items or services, HHA may provide these services either directly or under arrangement.

Balanced Budget Refinement Act of 1999 Removed Durable Medical Equipment from the Consolidated Billing Requirements Governing HHA PPS
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Impact of PPS Rates on HHA Payments by Type and Location Based on Audited Cost Report Sample HHAs Proposed Rule PPS Rates must be Budget Neutral to the IPS Limits Reduced by 15% in FY2001

Type of HHA — % Change from IPS to PPS
Proposed Rule

All Agencies 0.0

By Urban/Rural and Provider Type:

Rural
Freestanding:
For Profit -17.0
Govt. 46.4
Non-Profit 13.7
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Impact of PPS Rates on HHA Payments by Type and Location Based on Audited Cost Report Sample HHAs

Final Rule Payments Rates must be Budget Neutral to the IPS Limits in FY2001 (BBRA Change)

Type of HHA — % Change from IPS to PPS
Final Rule

All Agencies 0.0

By Urban/Rural and Provider Type:

Rural
Freestanding:
For Profit -7.50
Govt. 29.98
Non-Profit 13.28
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PROPOSED RULE		FINAL RULE	
Provider Based	10.1	Provider Based	5.31
Urban		**Urban**	
Freestanding: For Profit	-18.4	Freestanding: For Profit	-14.25
Govtl	50.9	Govtl	20.58
Non-Profit	20.5	Non-Profit	18.89
Provider Based	2.1	Provider Based	-2.50
By Provider Type:		**By Provider Type**:	
Freestanding: For Profit	-18.1	Freestanding: For Profit	-12.77
Govtl	47.9	Govtl	26.50
Non-Profit	19.4	Non-Profit	17.88
Provider Based	3.8	Provider Based	-1.03
By Urban/Rural:		**By Urban/Rural:**	
Rural Agencies	4.2	Rural Agencies	5.94
Urban Agencies	-0.4	Urban Agencies	-0.08
By Region:		**By Region:**	
Midwest States	21.8	Midwest States	14.77
Northeast States	21.4	Northeast States	15.37
Southern States	-15.5	Southern States	-16.75
Western States	-1.3	Western States	17.84

Grace Periods for OASIS Assessments and Plan of Care Certifications Associated with Transition of all HHAs to PPS Effective October 1, 2000	Grace Periods for OASIS Assessments and Plan of Care Certifications Associated with Transition of all HHAs to PPS Effective October 1, 2000
• Proposed a one-month grace period for both OASIS assessments and plan of care certification requirements	• HCFA is providing a one-time implementation grace period for OASIS assessments and plan of care certifications to alleviate transition

	concerns associated with all HHAs starting PPS with the same effective date of 10/1/00. • Plan of Care Certifications: For established home health beneficiaries as of September 1, 2000, HCFA is providing a one time grace period that provides a certification period up to a maximum of 90 days (September 1, 2000 through and including November 29, 2000). HHAs in conjunction with a certifying physician and HHA may have a one-time maximum 90-day plan of care certification. • The regulatory requirements governing the Medicare home health benefit before PPS would apply to the certification period up to and including September 30, 2000. • The plan of care must reflect a statistical break between the pre-PPS physician ordered services September 1,2000-September 30, 2000) and the post-physician ordered services (October 1, 2000-November 29, 2000). Included in the statistical break is the notation of the start of care date/first billable visit date for this patient under PPS OASIS Assessment Schedules Grace Periods for patients under an established plan of care: • On or after September 1, 2000 - September 30, 2000, HHAs may use the most recent OASIS start of care or follow-up to group for case mix.

	• On or after August 1, 2000-August 31, 2000, HHA have the discretion to complete the next schedule in September 2000 for case mix • On or after October 1, 2000 resume OASIS requirements governing last five days of episode certification period. **In order to take advantage of the grace periods, HHAs will need to use grouper software during September 2000.**